STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155455		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/14/2011		
	PROVIDER OR SUPPLIER		B. WINC	STREET A	ADDRESS, CITY, STATE, ZIP CODE EST 35TH ST N, IN46953	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0000	This visit v		F000	00			
		tion and State Survey. This					
	visit included the						
	Investigation IN0008712	on of Complaint 24.					
	1	IN00087124- tiated due to lack e.					
	Survey dat 10, 11, and	es: March 8, 9, 114, 2011.					
	Provider N	umber: 000557 (umber: 155455 ber: 100291240					
		nsterly, RN TC Namee, RN					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

58IT11

Facility ID:

	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE S COMPL	
	155455				03/14/2	011
PROVIDER OR SUPPLIER		<u> </u>				
'AN HEALTH CARE	CENTER					
			ID	PROVIDER'S PLAN OF CORRECTION		
`			TAG		TE	COMPLETION DATE
Karen Lew	ris, RN					
Census bed	l type:					
SNF/NF: 1	130					
Residential	1: 7					
Total: 137						
Census payor type:						
Medicare:	14					
Medicaid:	88					
Other: 35						
Total: 137						
Sample: 24	4					
•						
	1					
These defic	ciencies also					
reflect State	e Findings cited					
	•					
16.2.						
Ouality rev	riew completed					
(<u></u> p -					
	Census pay Medicare: Medicaid: Other: 35 Total: 137 Sample: 24 Residential These deficient accordar 16.2.	DEPOVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Karen Lewis, RN Census bed type: SNF/NF: 130 Residential: 7 Total: 137 Census payor type: Medicare: 14 Medicaid: 88 Other: 35 Total: 137 Sample: 24 Residential Sample: 7 These deficiencies also reflect State Findings cited in accordance with 410 IAC	IDENTIFICATION NUMBER: 155455 A. BUIL B. WIN PROVIDER OR SUPPLIER AN HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Karen Lewis, RN Census bed type: SNF/NF: 130 Residential: 7 Total: 137 Census payor type: Medicare: 14 Medicaid: 88 Other: 35 Total: 137 Sample: 24 Residential Sample: 7 These deficiencies also reflect State Findings cited in accordance with 410 IAC 16.2.	DENTIFICATION NUMBER: 155455 ROVIDER OR SUPPLIER AN HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Karen Lewis, RN Census bed type: SNF/NF: 130 Residential: 7 Total: 137 Census payor type: Medicare: 14 Medicaid: 88 Other: 35 Total: 137 Sample: 24 Residential Sample: 7 These deficiencies also reflect State Findings cited in accordance with 410 IAC 16.2.	DEPTIFICATION NUMBER: 155455 A BUILDING RWING RWING ROUNDER OR SUPPLIER AN HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Karen Lewis, RN Census bed type: SNF/NF: 130 Residential: 7 Total: 137 Census payor type: Medicare: 14 Medicaid: 88 Other: 35 Total: 137 Sample: 24 Residential Sample: 7 These deficiencies also reflect State Findings cited in accordance with 410 IAC 16.2.	DENTIFICATION NUMBER: 155455 A BUILDING WING O3/14/2 ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ROVIDER OR SUPPLIER T29 WEST 35TH ST MARION, IN46953 SUMMARY STATEMENT OF DEFICIENCIES MARION, IN46953 SUMMARY STATEMENT OF DEFICIENCIES MARION, IN46953 SUMMARY STATEMENT OF DEFICIENCIES MARION, IN46953 Karen Lewis, RN D

000557

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155455			(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/14/2011
NAME OF P	ROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE EST 35TH ST	
WESLEY	AN HEALTH CARE	CENTER	l l	N, IN46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	on March 1	6, 2011 by Bev			
	Faulkner, F				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155455		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/14/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F0280 SS=A	Based on reobservation the facility the dietary updated he indicated for reviewed worders for fin a sample for accurate health care (Resident # Findings in 1.) The cli Resident # reviewed o a.m. Diagnoses	ecord review, n, and interview, failed to ensure department alth care plans as or 1 of 1 resident with a history of fluid restrictions of 14 reviewed e and updated plans. (117) aclude:	F02		F 280: CorrectiveActions Taken for those Residentsaffected by the alleged Deficientpractice: Resident#117 care plan updat to reflectphysician order. Identificationof and corrective actionstaken for other residents havingthe potential to be affected bythe alleged deficient practice: Anyresider on fluid restriction has thepotential to be affected by the allegeddeficient practice. All complans havebeen reviewed and correctedif indicated. Measurestaken and systemic changes madeto ensure the alleged deficient practicedoe not recur: All careplans for residents on fluid restriction has been reviewed and amended ifneeded. An in-service on physicianordered fluid restriction been reviewed and amended ifneeded. An in-service on physicianordered fluid restriction actions will be monitoredant the QA system implemented ensure the alleged deficientpractice does not recur: A qualityassurance aud will be completed by the Dieta Manager/ designeeon all residents with fluid restrictionorder and their care plans weekly for three months and then quarterlyuntil 100% compliance. The results ofthe audit will be reviewed and anyconcerns addressed at the	nt the are es ave on ore d ditto	03/31/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155455		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/14/2011	
	PROVIDER OR SUPPLIER		729 WE	ADDRESS, CITY, STATE, ZIP CODE EST 35TH ST N, IN46953	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	limited to,	dementia and		Dateof Completion: March 2011	31,
	history of o	dehydration with			
	hyponatren	nia (low			
	sodium).				
		re plan problem,			
	revised on	3/7/11, indicated			
	Resident #117 had a fluid				
	restriction	of 1500 cc (cubic			
	centimeters	s). One of the			
	interventio	ns for this			
	problem w	as "Restrict			
	fluids per p	ohysician's			
	order".				
	The clinica	l record lacked			
	any current	t physician's			
	order for R	esident #117 to			
	have a fluid	d restriction.			
	During obs	servation on			
	3/10/11 at	12:10 p.m.,			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155455		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COMP	COMPLETED 03/14/2011	
	PROVIDER OR SUPPLIER		STREET 729 W	ADDRESS, CITY, STATE, ZIP COL EST 35TH ST ON, IN46953	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Resident #1	117 was in the				
	approximat various liqu	n and was served te 720 cc of uids with her container of ice				
	3/10/11 at 3 3/14/11 at 2 Resident #3 wheelchair pitcher of v	ervation on 1:40 p.m., and 2:15 p.m., 117 was up in a in her room. A vater and a glass in the resident's				
	the Directo 3/14/11 at 8 additional i requested r	interview with r of Nursing on 8:30 a.m., information was elated to any uid restrictions				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155455		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COME	(X3) DATE SURVEY COMPLETED 03/14/2011	
	PROVIDER OR SUPPLIER		729 WE	ADDRESS, CITY, STATE, ZIP CODE EST 35TH ST N, IN46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	for Resider	nt #117.				
		interview on				
	Director of	O				
	indicated sindicated s	he had reviewed d file" for				
	Resident #					
		ne resident once er for a 1500 cc				
	fluid restriction	ction, which had				
	10/6/09.	itiliued oli				
	Review of	a physician's				
	order, date	d 10/6/09, om the resident's				
		le" indicated an				
	order was i	received to e the resident's				
	fluid restric					
	10/6/09.	This indicated a				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/14/2011	
	PROVIDER OR SUPPLIEF			729 WE	ADDRESS, CITY, STATE, ZIP CODE EST 35TH ST N, IN46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	time period	d of 17 months					
	that this or	der had					
	continued a	as current in the					
	dietary hea	lth care plan.					
	Review of the current facility policy, revised 6/2005, titled "Care Plans", provided by the Director of Nursing on 3/14/11 at 12:30 p.m., included, but was not limited to, the following:						
	"Purpose:						
	plans, with from nursin disciplines	zed resident care specific plans ng and other					

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	OF CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION	1	DATE SURVEY COMPLETED
		155455	A. BUILDING B. WING		03	3/14/2011
	PROVIDER OR SUPPLIER		729	EET ADDRESS, CITY, STA WEST 35TH ST RION, IN46953	ATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	PLAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
	care.					
	^	ide a tool for				
		quality of care complishment				
	Procedure:					
	identify act	•				
	will be con determine t	the effectiveness veness of the				
		ms approaches nich are met or				

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: 155455			A. BUILDING B. WING			COMPLETED 03/14/2011	
NAME OF F	PROVIDER OR SUPPLIE	II R	B. WII	STREET A	DDRESS, CITY, STATE, ZIP CODE ST 35TH ST			
WESLEY	AN HEALTH CARE	CENTER	MARION, IN46953					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	discontinu	ed will be						
		ough with a						
	yellow hi-l	lighter, labeled as						
	D/C [disco	ontinued] and						
	dated"							
	3.1-35(c)(1	1)						

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		ONSTRUCTION	(X3) DATE SI COMPLE	ETED
		155455	B. WIN	G		03/14/20)11
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953				
(X4) ID	STIMM A DV S	TATEMENT OF DEFICIENCIES	1	ID	,		(X5)
PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE.	COMPLETION DATE
F0282	Based on re	ecord review and	F02	82	<u>F 282:</u>		03/31/2011
SS=D	interview, t	the facility failed			CorrectiveActions Taken for those		
	to ensure th	ne nursing staff			residentsaffected by the alleged		
	_	o on laboratory			deficientpractice: Unable tocorrect for resident #	1116	
		mely manner for			as	.110	
		ents reviewed			theurinary tract infection is resolved.		
	1 2	cian's orders for a			Identificationof and correctiv	e	
	urinalysis with culture and				actionstaken for other residents		
	_	in a sample of			havingthe potential to be affected		
	24. (Reside	ent #116)			by the alleged deficient practice:		
	Findings in	clude:			Anyresident with a physician ordered urinalysiswith culture and sensitivity		
	1.) The cli	nical record for			has thepotential to be affected the	by	
	Resident #1	116 was			allegeddeficient practice. The facility		
	reviewed of	n 3/8/11 at 11:05			lab policyhas been reviewed, a	ai IU	
	a.m.				staff hasbeen in-serviced to include		
	ъ.	0 0 11			completinga lab requisition properly,		
		for Resident			on orbefore 3/31/2011.		
		led, but were not			Measures taken and systemic changes	c	
	limited to,				made to ensure the alleged deficient		
	Parkinson's	s disease and			practice does not recur: Thefacility lab policy has been		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING		COMPLETED	
		155455	B. WIN			03/14/2011	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE EST 35TH ST		
WESLEY	'AN HEALTH CARE	CENTER		1	N, IN46953	_	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE DATE	
PREFIX TAG	altered mental A physician 11/30/10, in Resident # a urinalysis and sensitive possible sy urinary tracturinalysis in 12/1/10, incompresence of leukocytes notation on the laborate indicated the been contact wait for the	ntal status. n's order, dated ndicated 116 was to have swith culture		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ced vill m be rs udits erns	
		` ′					
	completed	•					
	medication	s were ordered.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	<u> </u>	MPLETED	
		155455	B. WING		03/1	4/2011
	PROVIDER OR SUPPLIER		729	EET ADDRESS, CITY, STATI WEST 35TH ST RION, IN46953	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE A CROSS-REFERENCED	TO THE APPROPRIATE	(X5) COMPLETION DATE
	any C&S rethe urinaly 12/1/10. During an the Admini Director of on 3/8/11 a additional requested rof a C&S romain the Assistant 3:15 p.m. the missing been noted the physici contacted.	Nursing (DoN) t 4:20 p.m., information was related to the lack				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155455		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED 03/14/2011	
	PROVIDER OR SUPPLIEF		729 WE	ADDRESS, CITY, STATE, ZIP CODE EST 35TH ST N, IN46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	for a urinal	ysis with C&S.				
	A physician	n's order, dated				
	12/06/10, i	ndicated				
	Resident #	116 had a new				
		urinalysis and				
	C&S if ind	icated.				
	The clinica	ıl record				
	indicated the	ne urine sample				
	was obtain	ed on 12/6/10 at				
	6:00 p.m.					
	The clinica	ıl record lacked				
	any urinaly	sis report for a				
	sample col	lected on				
	12/6/10. A	•				
	report, date	ŕ				
	indicated the	he lab had				
	l	urine sample for				
	testing on	12/9/10. The				
	urinalysis ı	report indicated				
	<u> </u>			<u> </u>		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155455	A. BUILDING		COMPLETED 03/14/2011	
		100400	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/14/2011	
NAME OF I	PROVIDER OR SUPPLIER	8		EST 35TH ST		
WESLEY	AN HEALTH CARE	CENTER	MARIO	N, IN46953		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	` `	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
	the specim	en was abnormal				
	with bacter	ria and				
	leukocytes	present. The				
	C&S repor	t, dated				
	12/11/10, i	ndicated the				
	culture was	s positive for the				
	organism,	Proteus mirabilis.				
	The report	contained a list				
	of antibioti	cs to which the				
	organism v	vas sensitive. A				
	physician's	order, dated				
	12/11/10, i	ndicated the				
	physician v	was contacted				
	and an orde	er was received				
	for Cipro (an antibiotic)				
	250 milligi	ams twice daily				
	for 10 days	S.				
	This indica	ated a time period				
	of 10 days	from the date the				
	first urine s	specimen was				
	sent for tes	ting and a final				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION	COMPL		
		155455	A. BUIL B. WING			03/14/2	011
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
WESLEY	'AN HEALTH CARE	CENTER			ST 35TH ST N, IN46953		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL] 1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	-	received and					
	antibiotic t	herapy ordered.					
	During an	interview with					
	the Admini	strator and DoN					
	on 3/10/11	at 2:50 p.m.,					
	additional	information was					
	requested r	elated to the					
	•	men having been					
	_	n 12/6/10 and					
	1	ort indicating					
	_	received" on					
	12/9/10.						
	During an	interview on					
	3/11/11 at 3	1:55 p.m., the					
	DoN indica	ated she had					
	consulted v	with the lab and					
		to determine					
	how and/or						
		•					
	specimen c						
	12/6/10 wa	s not tested until					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPL	ETED
		155455	B. WIN	_		03/14/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WESLEY	'AN HEALTH CARE	CENTER		1	N, IN46953		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	DATE
	12/9/10.						
	2.) Review	of the current					
	facility pol	icy, revised on					
	December 2	2009, titled					
	"Laborator	y - Test					
	Processing	and Reporting",					
	provided by	y the DoN on					
	3/14/11 at 1	12:30 p.m.;					
	included, b	ut was not					
	limited to,	the following:					
	"TD	T					
	"Purpose:						
	physician-o	ordered					
	diagnostic	test are					
	performed,	and to assure					
	that test res	sults are					
	promptly re	eported to the					
	physician.						
	Responsibi	lity: Licensed					
	Nursing an	d Director of					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155455		A. BUILDING B. WING		NSTRUCTION	COMPLETED 03/14/2011		
	PROVIDER OR SUPPLIER		72	29 WE	DDRESS, CITY, STATE, ZIP CODE ST 35TH ST N, IN46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	for monitor	•					
		ults are promptly the physician or itioner who em"					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155455	B. WIN		03/14/2011		
NAME OF P	PROVIDER OR SUPPLIER		•	STREET	ADDRESS, CITY, STATE, ZIP CODE	'	
			729 WEST 35TH ST				
WESLEY	'AN HEALTH CARE	CENTER	MARION, IN46953		N, IN46953		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE COMPLETION DATE	
F0323	REGULTIONTON	ESC IDENTIF TING INFORMATION)	F03		F323:	03/31/2011	
SS=D	Dagadana	haarvation	103	23		03/31/2011	
33-D	Based on o	oservation,			CorrectiveActions Taken for		
	record revi	ew, and			those residentaffected by the alleg	od	
	interview, 1	the facility failed			deficientpractice:		
	to ensure sa	afety alarms			Alarmingdevice was replaced resident#118 immediately at the	I	
	ordered to	help prevent			time of survey.Counseling given to		
	unassisted	ambulation and			CNA #7 who wasworking with resident		
	falls were i	n place and/or			#35.		
	functional	for 2 of 7			Identificationof and corrective actionstaken for other	re	
	residents re	eviewed for			residents havingthe potential to be		
	placement	of personal			affected by		
	alarms in a	sample of 24.			thealleged deficient practice Allresidents with alarms have		
	(Resident #	[‡] 118 and #35)			potentialto be affected by the alleged		
	Findings in	iclude:			deficientpractice. All residents withalarms were checked for placementand proper functioning. Anin-service on alarms and		
	1.) The cli	nical record for			facility policy hasbeen scheduled on	or	
	Resident #1				before		
					3/31/2011.		
	reviewed of	n 3/8/11 at 5:00			Measures taken and systemi	с	
	p.m.				changes made to ensure the alleged		
					deficient practice does not recur:		
	Diagnoses	for Resident			Thefacility policy has been		
	2148110505	101 1100100111			reviewed.		
					Anin-service on checking aları	ns	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/14/2011		
	PROVIDER OR SUPPLIER		72	29 WE	DDRESS, CITY, STATE, ZIP CODE ST 35TH ST N, IN46953	03/14/20	JII
	SLEYAN HEALTH CARE CENTER D SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PERCEDED BY FULL		M II PRE	IARION		ill he in five ude en e. d	(X5) COMPLETION DATE
	dated 2/21/	assessment, [11, indicated] [18] [18] [18] [18] [19] [19] [10] [10] [10] [10] [10] [10] [10] [10			s quarterly QAmeetings. Date of Completion: March 3: 2011	1,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155455		ľ	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/14/2011	
		155455	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	03/14/2	011
NAME OF I	PROVIDER OR SUPPLIER				ST 35TH ST		
WESLEY	AN HEALTH CARE	CENTER		MARIO	N, IN46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	assessment	, dated 1/6/11,					
	indicated R	Resident #118					
	required th	e assistance of					
	the staff for	r transfers and					
	toileting an	d had fallen on					
	one occasion	on since the last					
	assessment	was completed					
	on 12/15/10	0.					
	A health ca	re plan problem,					
	dated 8/23/	10 and last					
	reviewed o	n 1/4/11,					
	indicated R	Resident #118					
	was at risk	for falls related					
	to a history	of falls,					
	impaired ba	alance, and use					
	of psychoti						
	1 2	s. One of the					
	approaches	for this problem					
		resident to have					
		n when in bed.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155455		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE S COMPL 03/14/2	ETED	
	PROVIDER OR SUPPLIER		72	9 WE	DDRESS, CITY, STATE, ZIP CODE ST 35TH ST N, IN46953		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	A recapitul	ation of					
	physician's	orders, dated					
	2/12/11, ind	dicated Resident					
	#118 was to	o have a "Bed					
	alarm for sa	afety - check					
	placement	and function					
	every shift.	''					
	During an o	observation					
	conducted	with LPN #3 on					
	3/11/11 at 1	1:10 p.m.,					
	Resident #3	118 was resting					
	in bed and	requested to be					
	taken to the	e bathroom.					
	CNA #4 as	sisted Resident					
	#118 to a si	itting position					
	and then he	elped her up from					
	the bed. Tl	he bed alarm did					
	not sound v	when the resident					
	was assiste	d out of bed.					
	CNA #4 in	dicated the alarm					
	may have b	pecome					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155455				MULTIPLE COI TLDING NG	NSTRUCTION	COMPI 03/14/2	ETED
	PROVIDER OR SUPPLIER		P. "III	STREET A	DDRESS, CITY, STATE, ZIP CODE ST 35TH ST N, IN46953	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
		ed because the					
		was loose. LPN ecked the bed					
	alarm. The from the protection the bed was to the alarm lying on the LPN #3 atto the plastic at the alarm be connection	e cord leading ressure pad on s not connected h box and was e floor. When empted to plug alarm clip into ox, the was very loose. dicated the alarm					

PRINTED: 04/04/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		155455	B. WIN			03/14/2011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F0323	2.) The clinical re	ecord for resident #35	F03	23	<u>F323:</u>	03/31/2011
SS=D	was reviewed on	3/9/11 at 10:00 a.m.			_ CorrectiveActions Taken for	
	but were not limi and chronic pulm Resident #35 had	trent diagnoses included, ted to, fractured femur nonary heart disease. I a current physician's l1, for a bed alarm to be sident's bed.			those residentaffected by the allege deficientpractice: Alarmingdevice was replaced resident#118 immediately at th time of survey.Counseling given to CNA #7 who wasworking with resident #35.	for ne
	the resident had a problem listed as with serious injurintertrochanteric risk for further far balance. An interview was to provide a bed. Review of "Fall Worksheets," for the resident had a Review of a 3/2/Worksheet," indisustained a fall frinvestigation indinot on the resider fall as ordered by	r Resident #35, indicated fallen on 2/9 and 2/17. 11 "Fall Investigation ficated Resident #35 from the bed. The fall ficated the bed alarm was not's bed at the time of the			Identification of and corrective actionstaken for other residents havingthe potential to be affected by the alleged deficient practice: All residents with alarms have to potential to be affected by the alleged deficient practice. All residents with alarms were checked for placementand proper functioning. Anin-service on alarms and facility policy hasbeen scheduled on a before 3/31/2011. Measures taken and systemic changes made to ensure the alleged deficient practice does not recur: The facility policy has been reviewed. Anin-service on checking alarm	the c

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

58IT11

Facility ID:

000557

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A RUILDING			COMPLETED	
155455		A. BUILDING			03/14/2011	
			B. WING GO/14/2011 STREET ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER						
					ST 35TH ST	
WESLEYAN HEALTH CARE CENTER				MARIO	N, IN46953	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG				TAG	DEFICIENCY)	DATE
	indicated she had	d counseled CNA #7, who	İ		for	
		h Resident #35 on the		placementand functioning has been		3
	evening of the fall.				completedby 3/31/2011.	
					Howthe corrective actions w	ill
	Review of the cu	rrent undated facility			be	
	policy, titled "Fall Management Protocol",				monitoredand the QA systen	ו
		Director of Nursing on			implementedto ensure the	
		p.m., indicated the			alleged	
		p.m., marcated the			deficientpractice does not	
	following,				recur:	ho
					An auditwill be completed by t Directorof Nursing/Designee or	
	 Make sure fall 	risk assessments are			three	""
	completed on all	residents on admission			residentswith alarms per unit,	five
	-	the resident is identified			randomdays per week, to inclu	
		hat different intervention			all	
					shifts,for three months, and th	en
	are put into place	2?			quarterlyuntil 100% compliand	
					The auditswill be reviewed and	d
	2. A fall risk care	e plan should be initiated			any	
	for all residents on admission. Audit all resident clinical records for fall care plans and for appropriate interventions				concernsaddressed at the faci	ility'
					S	
					quarterly QAmeetings.	
	and for approprie				Data of Completion: March 2	,
	4 D 4 C 11	. , , ,			Date of Completion : March 3 2011	1,
		intervention in place			2011	
	immediately afte	r the fall. Make sure the				
	interventions are	dated and placed on the				
	fall care plan					
	*					
	9 When persona	l alarms are used there				
	-					
	needs to be speci					
		s for each resident/. Be				
	sure to monitor t	he functional ability of				
	the personal alar	ms and monitors"				
	•					
I			1		i	ı

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155455			(X2) MULTIPLE CC	INSTRUCTION		(X3) DATE SURVEY COMPLETED			
			A. BUILDING B. WING		03/14/2011				
NAME OF I	PROVIDER OR SUPPLIE	₹	STREET A	ADDRESS, CITY, STATE, ZIP CODE	3				
WESLEY	'AN HEALTH CARE	CENTER	729 WEST 35TH ST MARION, IN46953						
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	TION LD BE ROPRIATE	(X5) COMPLETION			
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)		DATE			
	3.1-45(a)(2)								

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
155455 A. BUIL В. WING				03/14/2011		
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER					EST 35TH ST	
WESLEYAN HEALTH CARE CENTER			MARION, IN46953			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		
TAG		LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)	DATE
F0371	Based on observa	Based on observation, interview, and		71	<u>F371:</u>	03/31/2011
SS=E	record review, the facility failed to ensure					
	the dietary staff did not wear nail polish				CorrectiveActions Taken for	
	while preparing a	and serving food for 2 of			those	- d
	4 dietary staff ob	_			residentaffected by the allego deficientpractice:	ea
		I failed to ensure pans			Immediatein-service for all die	tarv
		rere stored in a manner to			staffpertaining to storage of	···· ,
	• •	nation. This had the			personal	
	*				items,nail polish, artificial nails	l l
	*	t 129 residents served			properstorage of cutting board	S,
		acility kitchen. [Dietary			cereal	
	Staff #1 and #2]				bowls, andreview of sanitation and	
					crosscontamination policy and	
	Findings include	:			procedure.All nail polish and	
					artificial	
	The following ob	oservations were made			nails wereremoved at the time	of
	_	kitchen observation			survey.	
	_	a.m. to 9:25 a.m.:			Bowls andcutting boards wher	
	2, 0, 11 11 11 11 11				correctlystored after identificat of allegeddeficient practice.	ion
	1 A nurse was s	itting on a shelf with the			or unegeddenoient praetiee.	
	clean steam table	-			Identificationof and correctiv	e
	2. Three clean cutting boards were stored				actionstaken for other	
		•			residents	
	_	e of the three basin sink			havingthe potential to be	
		g faucet and were			affected by	
	1 2	er when the faucet was			thealleged deficient practice:	
	turned on.				Allresidents receiving a meal to have	lay
					thepotential to be affected by t	he
	A second observa	ation of the kitchen was			allegeddeficient practice.	
	made on 3/8/11 f	from 11:15 a.m. to 11:40			Immediate	
	a.m., with the fol	lowing observations			in-serviceof all dietary staff on	
	made:	V			facilitypolicy and procedure	
					related tosanitation and cross	
	1. Dietary Employee #1 was plating food to be placed on the food carts. The				contamination.	
					oontamination.	
	to be placed on the	ne rood carts. The			Measures taken and systemic	с

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
155455		B. WING		03/14/2011		
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER						
WESLEYAN HEALTH CARE CENTER			729 WEST 35TH ST MARION, IN46953			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE
		ernails were polished and			changes made to ensure the alleged	
		as not wearing gloves on			deficient	
	her hands.				practice does not recur:	
					Thefacility policy has been	
	2. A full rack of	cereal bowls being used			reviewed,	
	during the meal service had wet bottoms.				and thedietary staff have been	
	_	ee #1 indicated the bowls			servicedon sanitation and cros	s
		dish washer with water			contamination.Appropriate	
		pottom and can't dry.			signage has	nor l
	standing on the t	ottom and can't dry.			beenplaced to alert staff to proprocedures.	per
	0 D' - D 1	//2			procedures.	
		oyee #2 opened the lid on			Howthe corrective actions w	ill
		er two times with her			be	
	bare hands and c	continued to open drawers			monitoredand the QA system	1
	and remove uten	sils. She pulled up the			implementedto ensure the	
	back of her pants	s twice with her bare			alleged	
	hands and contin	nued to wrap utensils in			deficientpractice does not	
		or transportation to the			recur:	
	Fireside dining room. No handwashing was observed. The current 7/08, "Handwashing" policy and procedure for nutritional services was provided on 3/14/11 at 10:10 a.m., by the				An auditwill be completed by t	ne
					DietaryManager/Designee on storage	
					of bowls,cutting boards, and	
					employee	
					items toensure items are store	:d
					properlyfive random days per	
					week, to	
	Administrator.	The policy indicated			includeeach meal service and	
	hands should be	washed after handling			weekends, for threemonths, then quarterly	,
	soiled articles.				until	′
					100%compliance met. An aud	it
	The current 7/08	, "Personal Hygiene and			will	
		and procedure for			also becompleted by the Dieta	ry
		-			Manager/Designee on hand	
		ces was provided by the			washing	h
		n 3/14/11 at 10:10 a.m.			to preventcross contamination visualizingstaff while working,	
		ated food service			randomdays per week, to inclu	I
	employees may	not wear fingernail polish			each	

NAME OF PROVIDER OR SUPPLIES	<u> </u>			(X3) DATE SURVEY COMPLETED 03/14/2011		
WESLEYAN HEALTH CARE		B. WING 03/14/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953				
PREFIX (EACH DEFICIEN TAG REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) Pernails unless they are	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) mealservice and weekends, three months,then quarterly until 1	for	(X5) COMPLETION DATE	
Dietician on 3/14 indicated dietary polish unless the hands should be lid to the trash cothe cutting board.	iew with the Registered 4/11 at 12:45 p.m., she staff are not to wear nail by are wearing gloves and washed after touching the container. She indicated as are to be stored on the ot on the back ledge of		compliancemet. All audits wi reviewedand any concerns addressed infacility's quarterly QA meet Date of Completion: March 2011	ings.		
the three basin si 3.1-21(i)(1) 3.1-21(i)(3)	_					